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DIFFERENTIAL UTILIZATION OF THE HEALTH CARE DELIVERY SYSTEM BY MEMBERS OF ETHNIC MINORITIES

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Research and statistical reports of the 1960's strongly attested to the underutilization of the health care delivery system by members of ethnic minorities. For example, a 1968 national report on hospital utilization showed that a larger proportion of white persons was hospitalized than were persons of 'color.'[1] This was found to be true regardless of sex and age; but "... as family income increased, the rate for white persons and those of other races became closer." This fact not withstanding, each income level saw whites using hospitalization more than persons of 'color.'[2] Reasons for this difference in utilization were offered by the authors of the above report: "It is ...not just the orientation of physicians nor the age and sex of a person that dictates whether he will be hospitalized. Of prime consideration is one's realization or knowledge of his own condition and his attitudes toward disease, illness, and the medical profession."[3] Although cultural factors were not offered as reasons for the difference in utilization, Suchman, in his 1964 report on the Sociomedical Variations Among Ethnic Groups,[4] interpreted his findings of underutilization to be the result of cultural factors that influenced attitudes toward illness and the medical profession.

Although statistical reports and research of the 1960's indicated a lesser utilization of the health care system by members of ethnic minorities when compared to members of the compact majority, there was mention in the aforementioned 1968 statistical report of the increase in ethnic minorities utilization of hospitalization over that reported in 1965. This fact of an increase in utilization over a three year span suggested to this writer the possibility that there no longer would be found a significant difference in utilization over a 6½ year span. This possibility became the impetus for a library search through research published in the 1970's on ethnic minorities' utilization of the health care delivery system.

The initial questions guiding the search were

> What is the pattern of utilization of the health care delivery system by members of ethnic minorities?
>
> Which variables seem to be associated with levels of utilization?

The purpose of this paper is to explore answers to the above and related questions as they are found in research of the 1970's.

Definitions of Terms:

There are four concepts that descriptively must be defined: Ethnic Minorities, Compact Majority, Underutilization, and the Health Care System.

For the purposes of the author's exploration of published research, ethnic minorities were Mexican, Black, American Indian, Puerto Rican, and Oriental groups which are found in the United States. Each of these ethnic groups has a recognizable culture, except for the black group. Yet, this group also can be said to have a sub-culture. Furthermore, each minority, except the Puerto Rican group, has distinctive physical characteristics that identify its members as belonging to one ethnic group as opposed to another group. Even though the members of the Puerto Rican group cannot be distinguished readily from other Latin or often, Black groups, they do have subtle cultural, historical and lingual characteristics that differentiate their Puerto Rican group membership from other Latin and Black group memberships.

These five ethnic groups, when taken singularly, are considered to be in the minority, although if all members of the five groups were totaled ethnic minorities might comprise the majority in this country.

In addition to cultural and physical characteristics, each of these groups legally are considered non-white except the Mexican group. However, all have been in an inequitable position in this country, with respect to free access to education, employment, housing, and political representation.

The compact majority is comprised of all remaining members of ethnic and non-ethnic groups whose members are classified as "white" or Caucasian. On the whole, they have access to all of the opportunities that this country provides. In this paper, the term, "compact majority," will be used interchangeably with the term, white.

Whereas the above descriptive definitions of ethnic minority groups versus the compact majority were helpful to the author as she examined the research of the 1970's, the research reports apparently did not always find these definitions useful for their purposes. For instance, one national report on hospital utilization used the terms, "color" and "white." The term, "color," may be a step above the once usual term, "non-white," but it still fails to differentiate the groups so classified. Therefore, it is not any clearer than the term, "non-white."

Another deviation from the author's definition was that used by one of the studies on American Indians. This study ignored the fact that a person born of an Indian person and a white person legally is considered to be a member of the white racial group. Perhaps the researchers were attuned to the possibility that these persons are also in an inequitable position and therefore included them in their study of American Indians.

The definition of the concept, underutilization, seems to rest on the compact majority's average rate of utilization. Thus, underutilization is

a rate of utilization that falls below the compact majority's average, just as overutilization is a rate that is above the compact majority's average. Even when utilization rates are derived within minority ethnic groups, the interpretation of the information almost always relates to the majority standard. Unfortunately, the compact majority's average often is considered to be the normal occurrence. Thus, when the occurrence rate is above or below the white average, it is considered to be abnormal. Yet, such a judgement is misleading because we don't know what rate of utilization under what circumstances helps to prevent the onset of any illness or to treat an existing condition that can only be provided by members of the health care delivery system.

The Health Care Delivery System was viewed as including services directed toward the prevention or improvement of biologically and/or psychologically damaging conditions. Also included were services directed toward the maintenance of a level of health. Such services are offered through hospitals, clinics, nursing homes, or by private practitioners. Thus, the professionals providing care are medical doctors, nurses, psychologists, and medical and psychiatric social workers.

Findings:

The findings to be reported were culled from research and statistical reports published in the 1970's. All addressed the question of utilization of some service within the health care delivery system by 1) specifically Blacks, American Indians, and Mexicans who reside in this country. (No research could be found on health system usage by Puerto Ricans and Orientals.) or 2) all ethnic minorities.

The question -- What is the pattern of utilization of the health care delivery system by members of ethnic minorities; and what variables are associated with levels of utilization -- received answers according to factors both external and internal to the health care delivery system. Major external variables to be examined are attitudes toward health care providers and the health care system; culture; and social environmental factors. Internal variables to be examined include the availability of service and attitudes of health care professionals. It is recognized that variables which are external and internal to the health care delivery system interact with one another to produce an over-arching constellation which can explain utilization patterns.

External Factors

Attitudes: Gylys and Gylys showed that lower income Blacks did not hold negative attitudes toward medical institutions or the medical profession. No significant difference was found between the attitudes of low-income Blacks and those of middle-class whites.[5] As a matter of fact, low income Blacks tended to place considerable trust in the medical care delivery system and its professionals. They believed, perhaps naively, that they would receive the same quality of medical care in a public clinic as they would from a private physician.[6]

Cultural Factors: Only with Fuentes' study on Mexican migrant laborers was there an indication of cultural factors influencing the use of health care services. Ready access to services was offered through mobile health care units. Yet the Mexican male, in particular, did not avail himself of the care, but rather waited to seek attention until he had such a severe illness that hospitalization was required. Thus, these Mexican males had to remain in the hospital longer than their white counterparts.[8] A potentially plausible interpretation is that the cultural factor "machismo" operated to prevent the men from seeking care for minor health problems and to seek care only when illness had progressed to the point that they could not work or otherwise function outside the hospital.

Socio-Economic Status: Most of the research on ethnic minorities did indicate an association between income and/or social class and utilization rates of health care services. This association was found whether the study was about American Indians,[9] Mexicans,[10] or Blacks.[11] Lack of income was associated particularly with the underutilization of health care services. To illustrate, in one study of low income Black people, it was found that they tended to rank order priorities for the expenditure of their monies. The use of sparse funds to meet expenses connected with searching for higher paying job opportunities took priority over its use in seeking out-patient medical services or for hospitalization. Even when money is expended for health[12] care, it is in terms of crises. That is, when impairment of functioning becomes so pervasive or so obvious in the immediate situation that the individual feels that problem stands out above the rest, some action is taken.[13] It flows from this that seeking health care services for preventative or rehabilitative purposes is a relatively low order priority for the poor regardless of ethnicity.

Insofar as the utilization of public and private health services having economic determinants, it is noteworthy that the majority of ethnic minority groups use publicly sponsored health care; whereas, the majority of the compact majority use health services under private auspices.[15]

Furthermore, it is not surprising to find that middle income Blacks tend to operate as do their white counterparts; that is, they utilize the health care system in much the same manner as does the compact majority. Middle class Blacks are more akin to middle class whites than either to lower socio-economic Black or white classes.[16]

Internal Factors

Availability of Health Care: Several studies have sought to learn if the availability of health care services made a difference in utilization by members of ethnic minorities of those services. Some of these studies actually supplied services in certain geographical areas deemed more accessible to the target ethnic groups in order to examine whether the services would be utilized.[17] However, with some ethnic groups, even with greater availability, the utilization of the service was less than expected. For example, in a research and demonstration project with American Indians, antepartum, post-

partum and new born care were offered on an out-reach basis by a team of nurses, medical doctors, and social workers. A large proportion failed to keep appointments regularly. Yet, even among those who kept appointments on a consistent basis, the morbidity and mortality rates were not significantly different from those who did not keep appointments. This discouraging finding makes one wonder if medical care, alone, is as effective as we are led to believe. The researcher of the study tended to think that medical care, alone, was obviously ineffective in reducing morbidity and mortality. Yet they did find a decrease in those rates that had been found ten years earlier. The only interpretation that seemed credible was that there had been an improvement in the general living conditions of these Indians and that such an improvement allowed for improved health not the availability and utilization of the health care delivery system.[18]

Implications from such findings point to the necessity of improving living conditions among American Indians, as well as other ethnic minorities, as essential to reduction in morbidity and mortality rates. Of course, prerequisite to an improved status of living conditions is the elimination of social inequities affecting employment, education, housing and political representation.

Another study that sought to learn if the availability of medical services would affect the utilization of those services, supplied services within three different geographical areas of Los Angeles. These areas were comprised of poor Blacks, poor Mexican-Americans, and poor members of the compact majority (this latter group was used as a control). The comparison of utilization rates of these three groups revealed the highest level of use to be among the Black group.[19] This high rate by Blacks was found also to apply in a different study on psychiatric hospital admissions; whereas, a low utilization rate was found for Mexican Americans.[20] "It is interesting to note that when compared with their representation in the general county population [Sacramento], Afro Americans were considerably over-represented in this sample and Mexican Americans were under-represented."

The interpretation is offered here that Blacks have had a longer history in coping with the inequities of our American system in order not only to utilize health services, but also to make available other basic social opportunities. Thus, when a service is made available to them, they will use it. On the otherhand, Mexican-Americans are just beginning a concerted effort to eliminate these inequities and poor whites have not identified inequities around which they, as a group, can unite in battle.

Attitudes of Health Care Professionals: Attitudes of health care professionals often prevent the seeker of service from receiving that service. Medical doctors' attitudes about preference for the location in which their practices were to be established was examined in one study.[21] It was found that physicians desired to set-up practice in a community which reflected the income level to which they aspired and the ethnic group of which they were members. Given such preferences, coupled with the fact that the prejudices of the compact majority have assured that poverty exists disproportionately in ethnic minorities, one can expect that private medical care would not be readility available to ethnic minorities.

The attitudes of physicians about committing patients to hospitals also was found to be biased against members of ethnic minorities, particularly poor members. Markson's study, "A Touch of Class? A Case Study of the Geriatric Screening Process" revealed that physicians tended to turn away persons of low income or ethnic minorities, or those who did not look like them?[22]

A common assumption among health care professionals has been that the poor of ethnic minorities do not keep medical appointments. One study tested this assumption by putting a group of Spanish speaking women who, for the most part were receiving public assistance, in a group therapy program conducted in Spanish. It was found that the majority did keep appointments.[23] Since this common assumption was not supported by the Spanish speaking poor, it is possible that additional testing with other poor members of ethnic minorities would not support the assumption either. Thus, it maybe found that the assumption that the culture of ethnic minorities, combined with the culture of poverty is an invalid rationalization for not delivering health service to the poor of ethnic minorities.

Summary and Conclusions

There are differences in the utilization of the health care delivery system both within ethnic minorities and among ethnic minority groups. Within the Black ethnic group, the differences related to levels of income. Blacks of the middle class behaved with respect to the use of health care services as the white middle-class. It is suspected that the same relationship between utilization and income also would be found in the other ethnic minority groups.

When health care services deliberately were made available to ethnic minorities, differences in utilization were found among poor members of ethnic groups. Poor Blacks increased their rate of utilization; whereas, Mexicans did not use the services to the same extent. Only with Mexicans was there found evidence to support the notion that cultural factors may prevent usage of the health care delivery system. Yet, it might be expected that when Mexicans have a longer history of united struggles against barriers to their receiving needed services, they too will increase their utilization rates of health care services.

The situation presented by American Indians suggests that improvement in the basic living conditions, not the utilization of the health care delivery system, is the key to their improved health status. Since unemployment has been higher among Indians than other ethnic minorities, they have been unable to lift themseleves up without outside help. Also, as the Mexicans, it is only recently that they have had leaders to present their case to the compact majority.

Yet the effects of unemployment, as seen among the Indians, suggests that as long as there is inflation and unemployment poor members of ethnic

minorities may fall more heavily on a rank ordering of priorities for the expenditure of limited funds, as did the poor Blacks in Gylys' and Gylys' study. For the poor of all ethnic minorities, as well as the compact majority, health care may be the last priority. And considering the finding from the study on American Indians that utilization of the health care delivery system was not associated with a lowering of morbidity and mortality rates, placing health care at the bottom of one's expenditure priority list may be justified.

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